STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115607	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinewood Health and Rehabilitation	433 North McGriff Street Whigham, GA 39897

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the record review, staff interviews, and review of the facility's policies titled Abuse, Neglect and Exploitation, and Notification of Changes, and review of procedures titled Foley Irrigation Procedure, the facility failed to ensure two of three Residents (R) (R1 and R2) received the necessary care and services in accordance with physician orders. In addition, the facility also failed to ensure the physician was notified in a timely manner of significant changes in the resident conditions.On [DATE], a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents.The facility's Administrator, Director of Nursing (DON), Assistant Direction of Nursing (ADON) were informed of the Immediate Jeopardy (IJ) on [DATE], at 2:23 pm. The noncompliance related to the IJ was identified to have existed on [DATE].An acceptable IJ Removal Plan was received on [DATE]. Based on observation, record reviews, and review of facility policies as outlined in the Removal Plan, and staff interviews, it was validated that the corrective plans and the immediacy of the deficient practice was removed on [DATE]. Findings include:Review of the facility's policy titled, Abuse, Neglect and Exploitation dated [DATE] under the Policy section revealed, It is the policy of the facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.Review of the facility's policy titled, Notification of Change dated [DATE] under the Policy section revealed, The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification.Review of the facility's policy titled, Foley Irrigation Procedure dated [DATE] revealed, contact the physician or nurse practitioner to obtain order for irrigation of Foley catheter.1. Review of the admission Record revealed R1 was admitted to the facility with the following diagnoses that included but were not limited to hypertension, gastroesophageal reflux disease, type 2 diabetes mellitus, orthopedic implant joint prosthesis or bone plate left leg and morbid obesity.Review of the Order Summary Report revealed an order dated [DATE] for Ecotrin (Aspirin) oral tablet delayed release 325 milligrams (mg), give 325 mg by mouth two times a day related to fracture of tibia or fibula following insertion of orthopedic implant, joint prosthesis or bone plate left leg. Further review revealed, a phone order dated [DATE] for Foley catheter (18 French 10 milliliters (ml) balloon) care every shift due to wounds.Review of medical records revealed, on [DATE] at end of the day shift (7a-3p), Licensed Practical Nurse (LPN) AA inserted a Foley catheter for Resident (R)1 and after the Foley catheter was inserted, bleeding was noted in the Foley catheter tubing. LPN AA then irrigated the Foley catheter with sterile water without a physician order. The evening shift (3p - 11p) Certified Nursing Assistant (CNA) CC reported to LPN BB that R1 was not having any urine output and had blood in the Foley catheter drainage bag. LPN BB did not communicate to the physician that blood was noted in R1's Foley catheter drainage bag. LPN BB removed the Foley catheter as instructed by the former DON. There was no evidence that the physician gave the order nor was an order obtained (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115607	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/10/2026
NAME OF PROVIDER OR SUPPLIER Pinewood Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 433 North McGriff Street Whigham, GA 39897	

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	to discontinue the Foley catheter. Upon removal of the Foley catheter by LPN BB, R1 started bleeding from his penis and rectum. He began to have altered mental changes and loss of consciousness. Subsequently, R1 was sent to a local hospital.Review of the Emergency Medical Service Report (EMS) dated [DATE] revealed EMS received a call from the facility at 8:26 pm and arrived at the facility at 8:45 pm. A nurse standing by the entrance door giving report to EMS that the resident was bleeding from a Foley catheter removal and was having shortness of breath. It was noted that R1 was conscious and alert on 15 liters per minute (LPM) oxygen via non-rebreather mask and was responsive to EMS. R1 was transferred from his bed to the EMS stretcher. R1 became unresponsive and went into respiratory arrest. EMS personnel called for a fire unit to drive EMS personnel to emergency room (ER) while suctioning R1 mouth due to vomit that had exited from his nose and mouth. R1 was noted to be bleeding profusely from his penis with dark red blood and clots noted on the towels that was placed on his pelvic region. R1 was suctioned multiple times and bagged (use of bag-valve-mask) enroute to the emergency room with no improvement.Review of the first (named) hospital Emergency Documentation dated [DATE] revealed, R1 with a history of paraplegia presents to ER with concerns of respiratory distress. Associated with history is the fact that a Foley catheter was placed this morning, there was a large amount of blood that was expressed, and a decision was made this evening (by the nursing facility) to remove his Foley catheter. The onset of symptoms of shortness of breath was occurring approximately at the same time that this Foley procedure was taken place. The only other concern that was present is the fact the patient had a headache all day.Further review of hospital records revealed that R1 was transferred to a second hospital on [DATE] in critical condition and was admitted to intensive care unit (ICU). R1 was intubated and ventilated with multiple vasoactive drips administered. A urologist was consulted and a Foley catheter was placed at bedside in the unit with cystoscopy. Bleeding continued from numerous sites including his penis. R1 had received multiple blood components that included 11 packed red blood cells, four units of cryoprecipitate, three units of platelets and eight units of fresh frozen plasma. He sustained eight cardia arrests through the evening and early morning with failure to achieve return of spontaneous circulation and on the final instance, he was pronounced decease at 2:39 am on [DATE].Review of the Death Certificate dated [DATE] revealed the immediate cause of death was acute cardiac and respiratory failure, disseminated intravascular coagulation (DIC) and urethral injury. During an interview on [DATE] at 11:07 am, LPN AA revealed that at the end of her shift (day 7a-3p), she received the foley catheter order obtained by the former DON. When she inserted the foley catheter, she got urine and a small trace of blood. The Foley catheter went in with ease and R1 did not complain of any pain. R1 panicked when he saw blood in the Foley catheter tubing, LPN AA stated that she had reassured him and went and got some sterile water to irrigate the Foley catheter. LPN AA stated that she did not have an order to irrigate the catheter because Foley catheter irrigation was basic nursing. During an interview on [DATE] at 4:04 pm, CNA CC revealed on [DATE] she came in the facility, she saw that the R1 had a Foley catheter with no urine in the drainage bag and blood was coming out of his penis. She then left the resident's room and went to look for his nurse (LPN BB) to let her know about the blood. At 7:30 pm, CNA CC stated that she went into R1 room who was lying on his back and when she turned him over, she saw blood coming out of his penis and rectum. CNA CC stated that she reported to LPN BB that R1 was bleeding bad from his penis and rectum, and that he needed to go to the hospital. LPN BB came back and said she was given orders to take the catheter out. CNA CC went to LPN HH and asked her to call the former DON and let her know that the resident looked like he was going into shock. CNA CC stated she was upset because she felt LPN BB was not doing enough for R1 however, she later sent the resident out to the hospital.During an interview on [DATE] at 10:00 am, LPN BB revealed that she got report earlier that day that R1 had a Foley catheter and that LPN AA had gotten back some blood return and left the Foley catheter in place. Between 7:30 pm and 8:30 pm, she observed 100 ml of blood in R1's Foley catheter bag. The former DON who was on the phone with LPN HH overheard the conversation and told LPN HH to tell her to (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	pull the Foley catheter out and give the resident water to see if he could pee on his own. She stated that she pulled out the Foley catheter and that the [NAME] (located at the tip of the catheter) had 10 ml of water in it. Resident oxygen(O2) level began to drop during this time and EMS was called who arrived around 8:15 pm. LPN BB confirmed she did not have a physician order to remove the Foley catheter and that she was following the former DON instructions. She revealed she had called the physician but he didn't answer so she sent the physician a phone text that she was sending R1 to the hospital. At 8:28 pm the physician responded back, ok to her text. During an interview on [DATE] at 1:49 pm, LPN HH revealed that LPN BB was the assigned nurse for R1. LPN BB came to the nursing desk to ask her do she think she needs to call the doctor or send him out. LPN HH stated that she was on the phone with the former DON at the time. The former DON heard LPN BB and told her to flush the Foley catheter. LPN BB stated that she did not know how to flush the Foley catheter. The former DON then said, just take the Foley catheter out and we can have the physician to write a discontinuation order for the Foley catheter. 2. Review of medical records revealed, R2 was admitted to the facility on [DATE] with diagnoses that included but not limited to Human Immunodeficiency Virus (HIV), morbid obesity obstructive and reflux uropathy, anemia, chronic pain, hypertensive heart disease, cerebral Infarction affecting the left dominant side, uropathy, and an indwelling foley catheter.Review of R2's physician order dated [DATE] revealed, an order to obtain a urine sample for urinalysis and urine culture and to remove the Foley catheter.Record review of R2's medical records revealed that the Foley catheter was discontinued after admission; however, the resident was noted with some retention concerns and the foley was reinserted and an order for a urinalysis (UA)/ culture and sensitivity (C&S) in addition to a consult with a Urologist ordered due to urine being cloudy with a foul odor noted.Review of the Order Summary Report revealed R2 had an order dated [DATE] for a routine catheter change once a month with an indwelling catheter size 18 French (Fr) 10 cc balloon and to change leg securing devices with routine catheter change monthly and as needed. Further review revealed, an order dated [DATE] to irrigate catheter with 60 cc (cubic centimeter) normal saline or 60 cc sterile water as needed for leakage/blockage every eight hours as needed for urinary retention.Review of a laboratory requisition dated [DATE] for urinalysis with microscopic sample revealed no evidence that the urine sample was collected. On the handwritten laboratory requisition form dated [DATE] it was noted R2 was discharged to the hospital on [DATE] however there was no documentation to reflect that the resident was sent to the hospital and the census did not reflect a leave of absence. Further review of R2's medical records revealed, there was no indication that the urine specimen was obtained as ordered by the physician however, a Urology appointment was scheduled for [DATE] and was rescheduled for [DATE] at 2:00 pm.Review of (Named) hospital records History and Physical dated [DATE] revealed R2 admitted from nursing home with altered mental status and a concern for sepsis. It was noted that R2 had a chronic indwelling Foley catheter with a history of complicated urinary tract infections (UTI). The UA was positive for extremely turbid urine with 500 leukocyte esterase, 491 WBCs (white blood count). R2 was discharge back to the nursing home with a Foley catheter changed in the emergency department with no antibiotics indicated upon discharge on [DATE].Review of progress notes dated [DATE] revealed, R2 was observed with altered mental status and was transferred to the hospital via EMS to the ER.Review of (Named) hospital records History and Physical dated [DATE] revealed that R2 was hypotensive and met the criteria for septic shock with a likely source of a urinary tract infection or infected decubitus ulcer/osteomyelitis. It was also noted that R2's Foley catheter was changed out. Reportedly, the Foley catheter had been in there for more than a month. The Consultation Notes (Urology) dated [DATE] revealed R2 was last seen by the Urologist for a leaking Foley catheter.Review of the Death Certificate dated [DATE] revealed the immediate cause of death was urosepsis and pneumonia. During an interview on [DATE] at 3:32 pm Registered Nurse (RN) GG revealed that she had not changed the R2's Foley catheter on [DATE] and sent her to the hospital. She stated that she had checked on the resident and the resident had a low pulse oxygenation. She stated that she reported it (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	to the charge nurse and called the physician who gave orders to send R2 to the ER.During an interview on [DATE] at 1:37 pm, the current Administrator revealed that the expectation was that all residents receive excellent care from staff.The former Administrator and former DON were unavailable for interviews.

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review, staff interviews and review of the facility's policy titled Comprehensive Care Plan, the facility failed to implement care plan interventions for two of three Residents (R) (R1 and R2). Specifically, R1 was prescribed antiplatelet medication and had care plan interventions that included monitoring and documenting adverse outcome. In addition, R2 had a care plan for obstructive uropathy and an indwelling Foley catheter with care plan interventions to provide catheter care.On March 3, 2026, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents.The facility's Administrator, Director of Nursing (DON), Assistant Direction of Nursing (ADON) were informed of the Immediate Jeopardy (IJ) on March 3, 2026, at 2:23 pm. The noncompliance related to the IJ was identified to have existed on November 22, 2025.An acceptable IJ Removal Plan was received on March 5, 2026. Based on observation, record reviews, and review of facility policies as outlined in the Removal Plan, and staff interviews, it was validated that the corrective plans and the immediacy of the deficient practice was removed on March 4, 2026.Finding include:Review of the facility's policy titled Comprehensive Care Plan, dated 10/1/2024 under the section titled Policy revealed, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objective and timeframes to meet a resident's medical, nursing and mental ans psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. Under the section titled Policy Explanations and Compliance Guidelines revealed, 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being.1. Review of the admission Record revealed R1 was admitted to the facility with the following diagnoses that included but were not limited to hypertension, gastroesophageal reflux disease, type 2 diabetes mellitus, orthopedic implant , joint prosthesis or bone plate left leg and morbid obesity. Review of the undated care plan revealed that R1 is receiving antiplatelet medication therapy. The Interventions/Tasks included but not limited to, administer antiplatelet medication therapy as ordered; monitor skin for bruising, notify physician of new areas of bruising/discoloration; and monitor/document PRN adverse reactions of antiplatelet medication therapy (blood tinged or blood in urine, black, tarry stools, sudden severe headaches, nausea, vomiting, lethargy, sudden change in mental status. Review of the Order Summary Report revealed an order dated 9/7/2023 for Ecotrin (Aspirin) oral tablet delayed release 325 milligrams (mg), give 325 mg by mouth two times a day related to fracture of tibia or fibula following insertion of orthopedic implant, joint prosthesis or bone plate left leg.Review of R1 medical records revealed there was no evidence of a daily monitoring tool in place for the adverse risk for the antiplatelet medication.2. Review of the admission Record revealed R2 was admitted with the following diagnoses that include but were not limited to hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, morbid obesity, obstructive and reflux uropathy, and hypertension. Review of the undated care plan revealed, R2 has a foley catheter related to obstructive uropathy. Resident also has wounds to buttocks. The Interventions/Tasks included but not limited to, change foley catheter as ordered and as needed (PRN); provided foley catheter care per facility protocol, clean every shift and prn; and observe for signs/symptoms of infection (i.e. elevated temperature, cloudy urine in tubing, foul smelling urine, complaints of lower abdominal pain, change in cognition) and to report abnormal findings to the physician.Review of the Treatment Administration Record (TAR) dated 10/1/2025 through 10/31/2025 revealed no evidence of daily catheter care for day shift (7a - 3p) on 10/2/2025 10/3/2025 10/4/2025, 10/5/2025, 10/6/2026, 10/7/2025, 10/9/2025, 10/19/2025, 10/22/2025, 10/23/2025, 10/27/2025 and 10/30/2025; The evening shift (3p-11p) on 10/1/2025, 10/2/2025, (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	10/3/2025, 10/4/2025, 10/5/2025, 10/6/2025, 10/7/2025, 10/8/2025, 10/9/2025, 10/10/2025, 10/12/2025, 10/13/2025, 10/20/2025, 10/22/2025, and 10/23/2025; and the night shift (11p -7a) on 10/1/2025, 10/3/2025, 10/4/2025, 10/5/2025, 10/9/2025, 10/10/2025, 10/11/2025, 10/12/2025, 10/132025, 10/14/2025, 10/19/2025, 10/21/2025, 10/24/2025, 10/26/2025, 10/28/2025, and 10/31/2025 as indicated by blank boxesThe Documentation Survey Report v2 Nov-25 revealed that there was no evidence for day, evening and night shift of catheter care for day shift (7a-3p) on 11/1/2025, 11/2/2025, 11/3/2025, 11/4/2025, 11/5/2025, 11/6/2026, 11/7/2025, 11/10/2025, 11/12/2025, 11/13/2025, 11/15/2025, 11/16/2025, 11/17/2025, 11/19/2025 and 11/21/2025; The evening shift (3p-11p) on 11/1/2025, 11/2/2025, 11/3/2025, 11/6 /2025, 11/7/2025, 11/9/2025, 11/10/2025, 11/13/2025, 11/15/2025, 11/16/2025, 11/172025, and 11/21/2025; and the night shift (11p-7a) on 11/3/2025, 11/10/2025, 11/11/2025, 11/13/2025, 11/15/2025, 11/16/2025 and 11/21/2025 as indicated by blank boxes. During an interview on 2/16/2026 at 10:04 am, RN MDS Coordinator revealed that she was unsure why staff were not following the care plan.The former DON was unavailable for interview.Cross reference to F600

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review, staff interviews, and review of the facility's policy titled Incidents and Accidents, the facility failed to ensure one of one Hoyer lifts to transfer 13 residents was functional and free of defective parts. Specifically, the facility failed to remove a malfunctioned Hoyer lift and to ensure that it was properly repaired prior to the residents' use and the purchase of a new Hoyer lift. On March 3, 2026, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents.The facility's Administrator, Director of Nursing (DON), Assistant Direction of Nursing (ADON) were informed of the Immediate Jeopardy (IJ) on March 3, 2026, at 2:23 pm. The noncompliance related to the IJ was identified to have existed on October 4, 2025.An acceptable IJ Removal Plan was received on March 5, 2026. Based on observation, record reviews, and review of facility policies as outlined in the Removal Plan, and staff interviews, it was validated that the corrective plans and the immediacy of the deficient practice was removed on March 4, 2026. Finding include:Review of the facility's policy titled Incidents and Accidents, dated 4/1/2025 under the section titled Policy, revealed, It is the policy of this facility for staff to utilize the Risk Management portal to report, investigate, and review any accidents or incidents that occur or allegedly occur, on a facility proper and may involve or allegedly involve a resident. Under the section titled, Compliance Guidelines: revealed, 5. The following incidents/accidents required an incident report but are not limited to: equipment malfunction.Review of the undated Hoyer lift facility report revealed that 13 residents were transferred by a mechanical lift.A review of R1's progress notes revealed that on 10/4/2025, R1 was being transferred with a defective Hoyer lift. It was noted that two Certified Nursing Assistants (CNA) were transferring R1 from his wheelchair to his bed when the mechanical lift tilted over causing R1 to fall to the floor. R1 did not sustain any injuries but the next day had complaints of pain. Review of R1's x-ray report dated 10/5/2025 revealed no fracture, dislocation or bony destructive lesions noted. Review of the Task Type and Task Description form dated January 2025 through December 2025 revealed on 10/4/2025 that the maintenance director had assessed the defective and malfunctioning Hoyer lift on 11/8/2025 and 12/29/2025. However, the facility continued to use the defective Hoyer lift until parts ordered from an online vendor were available for the necessary repairs. The parts ordered included a motor, the arm lift and wheels.Review of a ticket order dated 8/3/2025 through 2/3/2026 revealed that a Lift 600 pounds capacity was ordered on 12/1/2025.During an interview on 2/16/2026 at 10:04 am, Registered Nurse (RN) Minimum Data Set (MDS) revealed that she knew R1 fell from the Hoyer lift. She revealed, after the fall the maintenance director assessed the Hoyer lift and refurbished it and to her knowledge the Hoyer lift was still in use until parts came in. During an interview on 2/16/2026 at 11:45 am, CNA II revealed that the facility had only one Hoyer lift in the building available for them.During an interview on 2/16/2026 at 2:45 pm, CNA RRR revealed they (CNAs) had to stand on the leg of the Hoyer lift to keep it from tilting over. She revealed she told the former Director of Nursing (DON).During an interview on 2/17/2026 at 10:14 am, the Maintenance Director revealed on the day R1 fell from the Hoyer lift, he assessed the lifts the same day and determined that the Hoyer lift needed parts. The Maintenance Director revealed the facility had an old Hoyer lift that was used for parts but did not have the parts needed to repair the current Hoyer lift. Therefore, he ordered the parts from an online vendor. He confirmed that the Hoyer lift continued to be used. He revealed that when the parts arrived, he refurbished the Hoyer lift. The parts that he had ordered from the online vendor were the motor, wheels and an arm lift. The Maintenance Director revealed that the new Hoyer lift was received in January 2026.During an interview on 2/24/2026 at 1:37 pm, the current Administrator revealed he was recently hired and was not aware of the malfunctioning Hoyer lift.The former Administrator was unavailable for an interview.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and the facility job description for the former Administrator and Director of Nursing, the facility failed to provide administrative oversight to ensure physician orders were obtained and implemented as written and failed to ensure adequate supervision of the quality of care was provided for two of three Residents (R) R1 and R2.On March 3, 2026, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents.The facility's Administrator, Director of Nursing (DON), Assistant Direction of Nursing (ADON) were informed of the Immediate Jeopardy (IJ) on March 3, 2026, at 2:23 pm. The noncompliance related to the IJ was identified to have existed on October 4, 2025.An acceptable IJ Removal Plan was received on March 5, 2026. Based on observation, record reviews, and review of facility policies as outlined in the Removal Plan, and staff interviews, it was validated that the corrective plans and the immediacy of the deficient practice was removed on March 4, 2026. Findings include:Review of the Administrator job description under the section titled Position Purpose, revealed, Leads, guides and directs the operations of the healthcare facility in accordance with local, state and federal regulations, standards and established facility policies and procedures to provide appropriate care and services to residents.Review of the Director of Nursing job description under the section titled Position Purpose, revealed, planning, organizing, developing and directing the overall operations of the Nursing Services Department in accordance with local, state and federal standards and regulations established facility policies and procedures and as may be directed by the Administrator and the Medical Director to provide appropriate care and services to the residents.1. Review of the admission Record revealed R1 was admitted to the facility with the following diagnoses that included but were not limited to hypertension, gastroesophageal reflux disease, type 2 diabetes mellitus, orthopedic implant joint prosthesis or bone plate left leg and morbid obesity.Review of R1's medical records revealed, on 11/20/2025 at end of the day shift (7a-3p), Licensed Practical Nurse (LPN) AA inserted a Foley catheter for Resident (R)1 and after the Foley catheter was inserted, bleeding was noted in the Foley catheter tubing. LPN AA then irrigated the Foley catheter with sterile water without a physician order. The evening shift (3p - 11p) Certified Nursing Assistant (CNA) CC reported to LPN BB that R1 was not having any urine output and had blood in the Foley catheter drainage bag. LPN BB did not communicate to the physician that blood was noted in R1's Foley catheter drainage bag. LPN BB removed the Foley catheter as instructed by the former DON. There was no evidence that the physician gave the order nor was an order obtained to discontinue the Foley catheter. Upon removal of the Foley catheter by LPN BB, R1 started bleeding from his penis and rectum. He began to have altered mental changes and loss of consciousness. Subsequently, R1 was sent to a local hospital.2. Review of medical records revealed on 9/19/2025, R2 was admitted to the facility on [DATE] with diagnoses that included but not limited to Human Immunodeficiency Virus (HIV), morbid obesity obstructive and reflux uropathy, anemia, chronic pain, hypertensive heart disease, cerebral Infarction affecting the left dominant side, uropathy, and an indwelling foley catheter.Review of R2's physician order dated 9/19/2025 revealed, an order to obtain a urine sample for urinalysis and urine culture and to remove the Foley catheter. Further review of medical records for R2 revealed that the Foley catheter was removed; however, the urine sample was not collected.Review of an order dated 9/22/2025 revealed, an order for a Foley catheter 18 French 10 milliliters (ml) bulb to be re-inserted due to retention concerns and an order for a urinalysis (UA)/ culture and sensitivity (C&S) in addition to a consult with a Urologist ordered due to urine being cloudy with a foul odor noted. Review of a laboratory requisition dated 9/22/2025 for urinalysis with microscopic sample revealed no evidence that the urine sample was collected. On the handwritten laboratory requisition form dated 9/22/2025 it was noted R2 was discharged to the hospital on 9/25/2025 however there was no documentation to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115607	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinewood Health and Rehabilitation	433 North McGriff Street Whigham, GA 39897

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	reflect that the resident was sent to the hospital and the census did not reflect a leave of absence. Further review of R2's medical records revealed, there was no indication that the urine specimen was obtained as ordered by the physician however, a Urology appointment was scheduled for 9/25/2025 and was rescheduled for 10/2/2025 at 2:00 pm.Review of (Named) hospital records History and Physical dated 10/15/2025 revealed, R2 was observed with altered mental status and was transferred to the hospital via emergency medical service (EMS) to the ER and admitted with altered mental status and a concern for sepsis. R2's Foley catheter was replaced in the ER on [DATE] and report was given to the nursing home regarding the Foley change.Review of R2's medical records revealed, R2 was sent back to the hospital for labored breathing via EMS services on 11/22/2025. R2 admitting diagnosis was septic shock and complicated urinary tract infection (UTI). 3. Review of medical records revealed that the facility had a malfunctioned Hoyer lift that was not removed from staff use. Subsequently, on 10/4/2025, R1 was being transfer with the Hoyer lift by two CNAs from his wheelchair to bed. In the process R1 had a fall due to the Hoyer lift tilting over during the transfer. The following day on 10/5/2025, R1 complained of pain and x-rays were obtained which were negative.Review of the facility Quality Assessment and Assurance process dated 12/23/2025 revealed current month (December) had nine falls and the previous month (November) had 15 falls. There was no evidence to support any other resident fell from the malfunction of the Hoyer lift.During an interview on 2/24/2026 at 1:47 pm, the current Administrator revealed that the expectation was that all residents receive excellent care from staff. He further revealed, he was recently hired in January 2026 and was unaware of these incidents.The former Administrator and former Director of Nursing were unavailable for interviews.